

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN8203	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 12/07/2020
NAME OF PROVIDER OR SUPPLIER BROOKHAVEN HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 2035 STONEBROOK PLACE KINGSPORT, TN 37660		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	Initial Comments Investigation of complaint #TN00052641 was conducted on 12/2/2020 - 12/7/2020 at Brookhaven Health and Rehabilitation. No health deficiencies were cited in relation to the complaint under Chapter 1200-8-6, Standards for Nursing Homes.	N 000			

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE